World Orthopaedic Concern

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This Newsletter is circulated through the internet, and through all WOC Regional Secretaries in the hope that they will be able to download and distribute it to those who may not be connected through the "net." It is addressed to all interested in orthopaedic surgery in areas of the world with great need but limited resources.

The theme of the forthcoming meeting of SICOT is "Orthopaedics in an Unequal World"; and in quest of equity, the emphasis is all on Teaching and Training. The first requires the dissemination of information; the second the painstaking guidance through treatment procedures, under conditions in which ingenuity with sound principles are essential. Both are important. In countries with a great need of medical manpower, the practical performance – the aim of training -- is the more important. We shall try to distinguish between the two. (Academia vs Pragmatism).

For those making plans to attend the annual meeting of SICOT in Hyderabad, (October 16th - 19th, 2013) we can offer a trail of some of the matters to be addressed..

1. "Non-Union; the Why and How" An Introductory essay on Union and its occasional failure; the influences which determine whether the process towards bone union is followed, or a false joint is created; and the indications (and contraindications) for surgical intervention. M. Laurence. (15 mins)

2. "An open debate on Organising Surgical Training", - its distinction from Teaching, and involvement with Service. This will be based upon a scheme of training devised in Kathmandu, collaborating with Dhaka (NITOR) and in association with Yangon. Prof. R.K.Shah, Prof G.W. Walker, Prof Iqbal Qavi, et al. (45 mins).

3. "Damage Control Orthopaedics, Specific Principles applicable in Areas with Limited Resources (the duplication of "hits"). Surgical planning. Prof. Arindam Asban (15 mins)

4. "Repair of Ruptured ACL -- sans resource" Experience of reconstruction without special equipment; in particular the immunity from infection without elaborate precaution. M.A. Mowbray. (15 mins).

The Nairobi Surgical Skill Course (NSSC)

Prof **J.A.O Mulimba,** Consultant Orthopaedic Surgeon, local Faculty Member, and the Chairman of NSSC, launched the Centre in November 2012, with the objective of improving surgical skills in sub-Saharan Africa. The driving stimulus was the appreciation that basic surgical skills are in short supply in the region, and that familiarity with the tools of our trade, is essential to progress in treatment.

The faculty which developed the curriculum for this Course was lead by Mr Adeshina Sergei Fawole MB BS MD FRCS (a general surgeon) and included both Kenyan and international experts. A special section of the course was devoted to Orthopaedic surgery. **Dr Asif Admani** from Meru, Kenya, provides the following appreciation of the Total Hip and Knee Replacement Courses, organized by **Prof. L.N. Gakuu**.

Practical demonstrations, organized by Johnson and Johnson, were performed on cadavers and covered both cemented and cementless arthroplasty. The first was on the hip in November 2012; the second, on the knee, in February 2013. Dr. Asif makes the following comments:_

"Theory; Important aspect of surgical biomechanics were covered in both the workshops. Review of the normal anatomy and geometry of joints is always valuable, although precise preoperative planning had to be limited for lack of radiology. (sic)

There were important aspects of experience shared by the consultants during the discussions. There was instruction (presented on CD) on the importance of correct version of cup and stem in their respective bones and to each other, and

the influence of this on dislocation rates and wear rates of the implants. Overall, the science behind arthroplasty is of paramount importance, and I believe that a workshop such as this really helps to review one's perspective.

- *Preoperative preparation*; since this session, I have become rather more cautious with patient selection.
- *Intraoperatively*; As regards total hip replacement, I have been able to improve my technique significantly. I feel I am able to expose the acetabulum much better, and that makes me comfortable doing the cup placement. I also managed to get a better 'feel' regarding ante-version during stem placement -- all this is with a relatively small incision.

With regard to knee replacement, again the exposure taught at the workshop enabled me to improve my exposure of the joint; the tibial surface was the primary focus. The technique of exposing the medial aspect of the tibia and thereby the posteromedial corner, really makes a difference in final placement of the implant.

T*eachers*; All the teachers at the workshop made it their business to impart all their knowledge to the participants. They shared whatever knowledge they have, controversy in the field, and skills they practice, with a true vision of the participants taking it in.

Appreciation was expressed to the following medical companies: Johnson & Johnson, Ethicon and DePuy Synthes, who contributed to the course expenses.

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This report reveals both the strength and the weakness of "Courses" in surgical technique. To be effective and valuable, they must be precisely geared to current skills and equipment available to those attending. They are necessarily brief, because time is expensive. By contrast the apprenticeship system, intimate participation over a significant period of time, provides an extra dimension to training. Ideally (in a perfect world) to work in a top class unit, (of which there are good examples in many countries) gives aspects of time and space and manual guidance in the course of surgery, that no pictures can. Every single surgical procedure will reveal abnormalities and differences, which is why experience polishes performance, and guided supervision is essential.

Training is a commitment that requires continuity; and complex implants can quickly acquire a bad reputation if not implanted in the appropriate patient, in perfect position, and under conditions of reliable sterility. In Orthopaedics generally, it is always perfectly possible to make a patient worse! When that happens, the local healers have to take over. Historically, today's experts have made mistakes, some were disastrous. Those mistakes do NOT have to be made again!

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WESTERN SAHARA

This office is pleased to refer to the appealing leaflet from **Medicins Sans Fronteires**. MSF proudly boasts its capacity to respond to emergency situations, "Collaborating with the rebels in northern Mali, with the French Military Task force in Timbuktu, with Syrian rebel groups, surreptitiously, and in various parts of the Congo. They work in tents, in caves, in abandoned hospitals; on cases of malaria, diabetes, yaws and childbirth, as well as extreme trauma. They rely absolutely on engineers, electricians and drivers for movement in, and carriage out. They leave behind undying gratitude, but no infrastructure. Their allegiance is to humanity – their debt, to their donors. They are the shock troops of disaster, but leave behind a vacuum for community rehabilitation.

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ETHIOPIA

WOC(uk) has been more identified with the Black Lion Hospital in Addis, ever since the Professorial Chair was established by Geoffrey Walker in the nineties. Visitors from UK have been regular and loyal in their association with the Orthopaedic Department of the Black Lion Hospital, and its growing senior staff – there are now ten consultants. Our contribution has been to help in the training of the residents. In a recent Newsletter (No.129) we wrote about extending the breadth and complexity of orthopaedic surgery, even to major joint replacement. And yet the foundation bricks of such practice are a cause of concern. The following report is from **Fintan Shannon**:-

“This my 9th visit, in 6 week stints, in as many years; I have to admit to some feeling of disappointment, even frustration, regarding promised progress.

For example**;** the maintenance of **medical records,** shows no evident continuity, which will be an absolute legal requirement one day soon! The **morning reporting** by the resident who was "on call" the day before, is always well done and used as an opportunity for instruction, with important lessons to be learned! Similarly each Thursday, the study day, academic topics are well presented by residents, but would be better if attended by more of the senior "Staff". There is a feeling that much “book work” has gone into the verbal preparations, with less attention to physical practice.

Emergency Room, (E.R. or A & E) – (*the provider of problems discussed at the morning reporting*,) is still like a war zone, chaotic and crowded, with between 30 and 50 patients and relatives to deal with. This is where residents learn “on the job”. They do the best they can with restricted resources, but often with no senior supervision. Delays are protracted well beyond the “golden hour”. With poor facilities for initial wound care, the consequent contamination proceeds to infection. The guiding presence of seniors would convert bitter experience into education

OPD/fracture clinics overlap in content. It is here that we see the "ER – non-admitted" patients, sometimes compound fractures, inevitably suffering the complications of delay. It is a sad truth that basic equipment as X-ray viewing boxes (in need of repair) are nobody’ s responsibility and elementary plaster casting is not taught. There has never been any response to the regularly repeated requirement for a competent supervisor of casts and traction gear

Ward hygiene is difficult to maintain, with many relatives virtually living in the ward. But pride could improve the infrastructure, toilet facilities, bed linen, etc.

The absence of **physiotherapists** on the wards is a major shame. Their

participation in musculoskeletal management does not yet seem to be accepted. Stiff joints and heel sores are thought to be the patient's problem. Canes or sticks must come through a relative and crutches are a luxury, with no one to demonstrate their use.

Access to the **OR,** operating room, shared with all others, is especially limited. The Main OR (Theatre) could perform so much better if somebody took control. Patients brought to the "gate", may not get in, if blood is not prepared; X-rays may be "missing", consent not signed; often there is no “drum" (theatre linen), no power, no water, no implant available. Cancellations are frequent.

Within the theatre, there is no typed list for someone to see/check and supervise. There is a notice board at the entrance to the suite, which lists the team, but not the procedure, nor the side, nor site of the surgery, and often not the patient’s name. These weakness will one day lead to tragic error.

Scrub-up facilities are limited. Basic instruments like drills/chucks, osteotomes, chisels &c are in a state of poor repair. Operating can be a nightmare with such equipment, worn from overuse and abuse, and no mechanical maintenance. Simple Implants like Kirschner wires, Steinmann’s pins, plates, nails, hemiarthroplasties may be available in the orthopeadic office store, but not in the OR nurse’s store.!
The OR in the Rehab Centre has similar problems, and other ones! Limited natural light presents a challenge when the power fails; no standby generator is wired in, and so operations occasionally have to proceed with illumination from a mobile phone.!

The guiding presence of senior staff members at each and every operating session should do much to improve standards, staff morale and patient throughput. The current **team structure** of 2 Groups, suggests that nobody is identified as responsible for a particular patient. There are now ten senior "staff" consultants in the department. I suggest that there might there be better “quality control” with five teams, each with five

residents?

All these comments are regularly made by surgical visitors, whose stay is too short to press for action to be taken. Moreover it is essential that the position of the visitor is that of a “guest advisor.” He (or she) has no authority, no responsibility, no power. It must remain for the senior staff to take action if they consider the visitors remarks to be helpful. In the mind of the visitor, comments are made, not by way of criticism, but in the hope that improvements can be effected. These defects do not reflect poverty of resources, but of will.
The visiting surgeon sees huge potential for this department, a massive clinical need, but gross lack of leadership.

Over the years I have tried my best to encourage an eager and energetic group of trainees, who clearly seek guidance and advice. The strength of the visitor may weaken if so little notice is taken of his (or her) constructive comments. What more can the visitor do to help Ethiopia to help itself? If it ranks as a poor country it is not for lack of ability or intelligence.

(Fintan Shanon)

TANZANIA. A message from *Moshi*, Tanzania, from HVOUSA, announcing that - “Volunteers are needed at Kilimanjaro Christian Medical Center for 2-4 week assignments. Volunteers provide training through lectures and presentations, participating in clinics and rounds, as well as hands-on demonstrations of techniques of treatment and methods during surgery. The principle need is for generalists, but sub-specialists are also needed. Please contact the **program department of HVO** for more information.”

(M. Laurence)